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By-Richman, Vivien
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The Mental Health Services Program (MHS) was established in 1965 to provide services to schools including identification of emotionally disturbed children, treatment, training school personnel in mental health principles, and serving as a resource for a variety of problems. Six adjustment classes in elementary schools and six resource rooms in secondary schools were developed and supported by consultation conferences aimed at psychoeducational diagnoses and including teachers, a psychiatrist, and social workers. Crisis consultations were utilized to handle emergency cases. In the 1966-67 school year, 65 of the 400 crisis consultations concerned suicide; seminars with interested school personnel served 115 teachers, supervisors, and principals; and 727 children, aged 6 to 19, were referred to the program, 75 of whom were admitted to the adjustment classes and 225 to the resource programs. Aggressive behavior was the most frequent cause of referral. No significant differences in achievement, report card grades, citizenship, absence, or tardiness were found; out of 1,392 ratings by teachers on student behavior, relationship with other children and relationship with authority showed the highest percentage of improvement (69%) while conformity to school rules and participation in class activities were next (64%). Conclusions were that the program was a promising beginning toward meeting the mental health needs of students. (RJ)

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TITLE I PROJECTS

MENTAL HEALTH SERVICES

1967 REPORT

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MENTAL HEALTH SERVICES PROGRAM
1967 REPORT

Vivien Richman
Program Evaluator

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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Pittsburgh Public Schools
Sidney P. Marland, Jr., Superintendent

5. MENTAL HEALTH SERVICES PROGRAM

Introduction

History of the Program

In 1954, the Pittsburgh Board of Public Education recommended the employment of a psychiatrist as a consultant to the Pittsburgh Public Schools. Although this recommendation was not implemented for some time, a broader program was conceived over the years through the combined thinking of the Division of Pupil Services, the Division of Instructional Services, and the Division of Medical Services.

Under the joint sponsorship of the Pittsburgh Board of Public Education's Team Teaching Program and the Health and Welfare Association, the first mental health team was established in the Hill District in 1961. The team functioned much as a child guidance clinic housed in a school system. It was selective in accepting referrals from school personnel and traditional in its methods of diagnostic evaluation. Fifty-one children were seen individually in the 1962-1963 school year, 74 in 1963-1964. The complete program was described in a report published by the Pittsburgh Board of Public Education in 1964.[1]

Under the Division of Compensatory Education, a second mental health team was established on the North Side in June 1965. Both teams

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[1] Ruth Kane, Aileen Birmingham, and R. A. Kerchner, A Comprehensive Mental Health Team Approach to Learning Problems of School Children in a Culturally Deprived Area, Mimeographed Report, Pittsburgh Public Schools, 1964.

were discontinued when funding from OEO expired in July 1966. An evaluation of these programs was included in a report published in 1966 by the Pittsburgh Public Schools.[2]

The present Mental Health Services Program (MHS) was established in November 1965 by a three-year grant to the Pittsburgh Public Schools from the Maurice Falk Medical Fund. This grant was supplemented by OEO and Ford funds which are expected to be replaced by state reimbursement beginning in September 1967. The program, a subdivision of the Office of School Services, was set up to provide comprehensive mental health services to the schools. Administrative relationships between the psychiatrist-director of the MHS Program and school personnel were considerably different from those of the previous mental health teams. The present staff is an integrated, organic part of the central administration and is seen as such by most school personnel.

Description of the Program

Philosophy. Several assumptions underlie the development of the MHS Program:

1. The school is the primary case-finding agency in the community for the identification of emotionally disturbed children. In view of compulsory attendance and the central importance of

[2] Vivien Richman, Mental Health Services, Pittsburgh Public Schools, 1966.

the school in the life of the child, the school is also the primary mental health agent. This position is taken by many writers in the field:

> The school's responsibility for mental health pertains not only to the happiness and adjustment of individuals, but also to healthy group living in society at large. Through its influence on the developing personalities of children, the school plays its distinctive role in relation to the mental health of the community.[3]

An even stronger position was taken by the Director of the Mental Health Study Center of the National Institute of Mental Health:

"I am persuaded that no formal publicly supported institution plays a more crucial role or harbors more potential in behalf of individual mental health than our school system."[4]

2. Treatment or help for emotionally disturbed children, if not provided in the schools, may not be provided at all. Of the estimated number of emotionally disturbed children in Allegheny County, only about 5 percent received treatment from other community agencies.[5] The remaining untreated 95 percent constitute the major focus for concern by the schools.

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[3]Community Programs for Mental Health, ed. Ruth Kotinsky and Helen Witmer (Cambridge, Mass., 1955), p. 216.

[4]M. Krugman, Orthopsychiatry and the School, Amer. Orthopsychiatric Assn. (New York, 1958) p. 135.

[5]Report of the Committee on Services for Emotionally Disturbed Children, Health and Welfare Assn. of Allegheny County, February 1967, p. 10.

3. Traditional evaluative and diagnostic procedures have proven to be an uneconomical utilization of scarce mental health professionals.[6] The approach and the techniques of the MHS Program comprise an effort to deal constructively with this problem.

4. Considering the existence of mental health problems within the school and the acknowledged scarcity of mental health professionals, the MHS staff places considerable importance on training school personnel in mental health principles. Teachers stand in a critical relationship to the child, as stated by Louis Hay: "The community must recognize that teachers are the only trained social representatives who are in a position to contribute toward the better adjustment of the greater number of disturbed children."[7] There have been many other attempts to establish school-based programs to meet the needs of emotionally disturbed children. Kvaraceus[8] and Abramovitz[9] concentrated their efforts on

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[6]G. Caplan, Prevention of Mental Disorders in Children, (New York, 1961), p. 16.

[7]"A New School Channel for Helping the Troubled Child," Amer. Jour. of Orthopsychiatry, XXIII (1953), p. 676.

[8]William C. Kvaraceus, "Helping the Socially Inadapted Pupil in the Large City Schools," Exceptional Children, XXVIII (1962), 399-404.

[9]A. B. Abramovitz, "Exploring Potentials for Mental Health in the Classroom," Mental Hygiene XLIII (1959), 253-259.

teacher-training programs of in-service education and mental health seminars for school personnel. Felick[10] and Knobloch[11] also reported programs of in-service education and mental health seminars for school personnel.

5. The MHS Program was designed to be a resource to the total school. Facilities for the treatment and/or education of disturbed children in the community are scarce or non-existent. In some instances, the school has been forced to handle problems which should have been dealt with by other community agencies:

> The most serious social consequence of the compulsory attendance law may well be that, since its inception, all of our child-caring, remedial, and correctional agencies have fallen steadily behind the mounting need for their services. The need has been comfortably obscured by the expanding custodial role of the public schools, who are now expected to contain and somehow educate all children regardless of their degree of emotional disturbance and/or anti-social behavior, and/or inability to profit from what restricted programs the schools offer to the non-average.[12]

If schools identify and refer disturbed children to the appropriate agency, the community will be able to get a more accurate and realistic picture of urgent, unmet needs and plan accordingly.

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[10] M. L. Felick, "Observations on the Psychological Education of Teachers in a School-Based Mental Health Program," Mental Hygiene, XXXVIII(1954), 374-386.

[11] P. Knoblock and R. A. Garcea, "Toward a Broader Concept of the Special Class for Emotionally Disturbed Children," Exceptional Children, XXXI (1965), 329-335.

[12] Stonewall B. Stickney, "Schools are our Community Health Centers," Paper presented at Amer. Psychiatric Assn., 1967, p. 4.

The school may logically be recognized as the central agency in a comprehensive mental health plan for the community.

6. With the current MHS Program functioning somewhat as a demonstration project, it is hoped that the tempo, the methods, and the delivery of mental health services in the community will shift in the direction of the educational model, in both diagnostic and treatment approaches.

Components of the Program. There are four major components of the MHS Program: (1) the adjustment class and resource room programs, (2) consultation conferences, (3) crisis consultations throughout the school system, and (4) in-service education in mental health for school personnel. Other related activities developed as the program became established.

Adjustment Class Program. This program was designed to provide an optimum educational and therapeutic environment for elementary school children whose emotional maladjustments preclude their functioning adequately in the normal school program. Based on the principles of maximum containment of the child by the school and minimal use of the program, its ultimate purpose is to enable the school to cope with the child and the child to return to regular classes as soon as possible.

The first adjustment class was established at Colfax Elementary School by the Department of Special Education in September 1964, before the MHS Program was begun. The second class, opened early in 1965 at Weil Elementary School, also preceded the current MHS Program.

Both classes, taught by graduates of Syracuse University's Department of Special Education, were based on the educational methods of Cruickshank.[13] The third class was opened in March 1966 at Columbus Elementary School. In September 1967, the MHS staff established four new adjustment classes located at Arsenal, Friendship, Holmes. and Morse elementary schools. Although teachers for these programs were recruited at the last minute because of funding difficulties and had not been trained in the Cruickshank method, there was an effort made at patterning all the classes after the original one.

In-service education of these teachers occurred during the bi-weekly consultation conferences in their schools (described later in this report) and during bi-weekly meetings held after school hours with the psychiatrists, Program Coordinator, and Research Consultant. In-structional supervision was minimal until May 1967 when a specially trained supervisor was designated.

In general, there are four elements in the teaching environment common to all the classes: (1) reduced environmental stimuli, (2) reduced space, (3) a highly structured program, and (4) special teaching materials of increased stimulus value. Carrels or folding screens are used in each classroom to provide reduced working space and to eliminate

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[13] William M. Cruickshank, Frances A. Bentzen, R. H. Ratzeberg, and Mirian Tannhauser, A Teaching Method for Brain-Injured and Hyperactive Children (Syracuse, 1961).

distractions. In addition to regular teaching aids, teacher-made materials are utilized to help focus the child's attention on specific learning tasks. In some of the classes, special equipment and materials are provided for children with perceptual-motor dysfunctions in order to help establish and develop eye-hand coordination, figure-ground perception, and other skills.

The teacher does not function as a therapist. His major objective is to enable the child, through a wide variety of techniques, to establish internal control of his own behavior and to acquire or develop the skills required for learning. When a child is first assigned to the adjustment class, he can, if necessary, spend his entire school day there. As soon as it is deemed appropriate by the teacher and the consultation conference group, he is gradually reintegrated into regular classes. Continued support of the child and the regular teacher to whom he is assigned is carried out by the adjustment class teacher.

Resource Room Program. In February 1965, Technoma, a private therapeutic day-care center for emotionally disturbed children, and the Pittsburgh Public Schools jointly established a demonstration program at Schenley High School. The program, designed to assist the disturbed child in his academic work and social adjustment within the school setting, was known as the resource room. It was taken over by the MHS Program in September 1966, although Technoma continued to provide some consultative services to the resource room teachers. Five

additional resource rooms were established by the MHS Program in September 1966. These rooms were located in Fifth Avenue, Gladstone, Latimer, South, and Westinghouse high schools.

The resource room, while sharing a common purpose with the elementary school adjustment class, functions with somewhat more flexibility. For the most part, students use the room primarily during study hall periods, although they are not restricted to these periods. Students receive specific academic instruction, tutoring, and remedial work. Assignments are received from regular teachers, and frequent communication occurs between resource room teachers and other school personnel regarding current assignments, behavior, and other related topics.

Referral and admission procedures (described later) were established for both resource rooms and adjustment classes. However, these procedures are not rigidly adhered to in the secondary schools where the resource rooms are also used informally, before and after school, and between classes. Some of the students are "self-referrals" who come to the resource room if they are upset, troubled, or on the verge of an emotional outburst. It then becomes the responsibility of the resource room teacher to notify the regular teacher of the student's presence in the room.

The resource room teacher uses a variety of teaching materials, ranging from standard textbooks to special teacher-made materials. The primary emphasis in both the resource rooms and the adjustment classes

is educational, although there are remedial, preventive, corrective, and therapeutic aspects as well.[14]

Consultation Conferences. The adjustment class and resource room programs are supported by consultation conferences in the schools. Every two weeks a psychiatrist and a social worker from the MHS staff spend a half-day at each of the participating schools in conference with appropriate personnel. Based on the assumption that teachers can generally identify children who are "different," the conferences are teacher-centered. Teachers are frequently able to supply vital information about the child's learning difficulties, his social behavior, how he and the school adapt to each other, and his family background. Other school personnel knowing the child--the principal, school social worker, psychologist, counselor, school physician, or nurse--share their knowledge or insights with the conference group. Frequently, a two-hour discussion period produces a collection of information which might have taken weeks or months to collect through more traditional methods. If more information is required, the appropriate person in the conference group takes the responsibility of securing it for the next meeting.

One purpose of the consultation conferences is to discuss children referred to the program. (Referrals are made by any school staff

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[14] Vivien Richman, Stonewall B. Stickney, and George J. Wilson, "Mental Health Services in the Pittsburgh Public Schools," Jour. of the Internatl. Assn. of Pupil Personnel Workers (March 1967), pp. 91-95.

member and directed to the principal in the elementary schools and to the Counselor-Coordinator in the secondary schools.) The conference attempts to determine whether the referred child can benefit from assignment to the adjustment class or resource room program or whether he merely needs additional support in his regular class. Conference members decide whether the child is so severely disturbed that the school is perpetuating an undesirable social situation by continuing in an impossible and inappropriate custodial role. An effort is made, when possible, to maintain the disturbed child's placement in some part of the regular school program so that he is not completely separated from the mainstream of school activities.

At the end of the school year, the two psychiatrists discovered that, working independently, they had arrived at a common basis for decisions on the disposition of referrals. They agreed that the major determinants in making this decision were the degree of the child's (1) reachability; (2) disability; and (3) containability in his school, community, and family. The interaction and inter-relationships of child-family-school-principal-teacher-community were the bases for decisions in planning for the child.

The conference group also attempts to determine if the disturbed child has elected a friend from among the faculty. If such a relationship exists, the group attempts either to reinforce that relationship or to make it more informed and purposeful. Similarly, if the parents have

elected a friend in the school, that relationship is supported. In this way, the MHS staff assisted school personnel in locating, identifying, supporting, and utilizing potential or existing mental health resources in their own schools.

The MHS consulting group interviews the child and his parents only when the information presented at the consultation conference is either puzzling or alarming. During the school year 130 children were seen by the Psychiatrist-Director and by the Consulting Psychiatrist, although 727 children were served by the program. This was an economic utilization of one full-time and one half-time psychiatrist in a large urban school system.

By discussing, reviewing, and planning for the disturbed children in the school, the conference group provides systematic and practical support for the program. The process of joint planning for each of the children is self-correcting because the effectiveness of the plan can be evaluated during the bi-weekly conferences and modified accordingly. The conference also serves as a teaching seminar for participating school personnel.

The diagnostic process of the consultation conferences differs from more orthodox, clinically-oriented staffings or case conferences. The goal of the conferences is to arrive at a psychoeducational diagnosis and specific prescriptive recommendations. The presentation of long, formal, technical reports written in psychiatric or psychological

terminology is avoided.

Crisis Consultations. This activity occupies a large proportion of the MHS staff's time. During the 1966-1967 school year almost 400 crisis consultations occurred in 82 schools. Referrals came primarily from principals, but the MHS staff also consulted on cases referred by members of the central administrative staff.

The philosophy, diagnostic approach, and procedures of the crisis consultations are similar to those of the regularly scheduled consultation conferences. For all consultations, an effort is made to invite representatives of community social agencies to participate if either the child or family under discussion is known to them or if it seems likely that the child or family may be referred to them. Juvenile Court, Family and Children's Service, Child Welfare Services, Children's Hospital, Western Psychiatric Institute and Clinic, St. Francis Hospital, and the Department of Public Welfare were among the agencies who sent representatives to the consultations in the past school year.

There were several purposes for inviting these representatives:

1. To ensure closer working relationships
2. To share with other agencies important information which only the school might possess. For example, a child might present acceptable behavior during a one-hour period in a treatment center, but be virtually uncontainable in a classroom.

3. To plan together for the troubled child in deciding which agency should be responsible and in avoiding unilateral actions regarding treatment or management plans
4. To develop or reinforce a pattern of inter-agency action which eliminates unnecessary multiple diagnoses and excessive paper work and provides more effective delivery of services

The most urgent of the crisis consultations were those involving children who had threatened or attempted suicide. The MHS staff assumed that all suicide threats were "serious" until proven otherwise. It is notable that the community has considered juvenile suicide threats "not serious" unless the action taken is successful or nearly so.

The suicidal child and his parent (s) were seen by a MHS psychiatrist and social worker, usually within 24 hours after the referral was received. This type of referral was given first priority. During the 1966-1967 school year, 65 such referrals were made--43 at the secondary school level and 22 at the elementary level. How many suicide threats or attempts occur in the school population other than those referred to the MHS Program is not known. Emergency facilities in the community for dealing with juvenile suicide attempts are grossly inadequate and temporary protective facilities scarce.

Two case histories will illustrate the experience of the MHS Program in trying to deal with suicide attempts and threats in the face of these

limitations.

Danny, a 10-year-old Negro boy in a poverty neighborhood, was living with his widowed, alchoholic, 54-year-old mother who was unable to care for herself. He had a history of attempted suicides. After being involved in a fight with another child about a week before Christmas, he was required to bring his mother to school. He appeared in the school yard after having cut his abdomen with a razor blade. School officials took him and his reluctant mother to the hospital where, after a loss of considerable blood, he was given 10 stitches and sent home.

The MHS staff was notified and Danny and his mother were seen the following day. His mother evidenced no alarm or concern. The psychiatrist described Danny as a child "on the brink of psychotic depression or schizophrenia." With the holidays approaching, it was feared that Danny's mother would go on an extended drinking spree, leaving Danny at the mercy of his self-destructive impulses.

Juvenile Court was contacted by a supervisor from the Office of Pupil Services of the Pittsburgh Public Schools. Acting on the advice of the MHS psychiatrist, an attachment was issued to have Danny brought into the Detention Home. He remained there until he was transferred to a temporary shelter operated by Child Welfare Services. Eight months later, in July 1967, Danny was still at the shelter. The prospects of a foster home or other residential placement are dim.

Theresa, a 14-year-old student in a predominantly middle-class high school, was referred to the MHS staff by the school social worker for having threatened suicide. Viewing her situation as intolerable, Theresa had no desire to continue living. Her parents, who were on public assistance, had both been in and out of mental hospitals. Theresa's few clothes were in very poor condition. She lived in a filthy house with five dogs, a cat, and two hamsters. The gas and light had been turned off.

After school, Theresa rushed home to do her homework while there was still daylight. When it got dark, she and her younger brother Richard went to bed to keep warm, while their parents played cards by candlelight. Richard, an elementary-school student, was beginning to show signs of depression, hopelessness, and alienation similar to Theresa's.

The MHS staff initiated a conference involving the people and agencies who had been active with the family. These included the elementary and secondary school social workers; the principal and two teachers from Richard's school; the family's minister; representatives from the Family and Children's Service, who had dealt with the family since 1958; and people from the Department of Public Welfare and Child Welfare Services. The family's history and present circumstances were reviewed. Emergency arrangements were made to restore heat and light in the house. There was a general agreement that both children should be removed from

the home and the parents encouraged to enter treatment. However, no residential facilities were available in the community for either child. As an interim measure, the MHS staff was able to secure emergency hospitalization for Theresa at St. Francis Hospital. The school social workers agreed to give both children continued daily support for the rest of the school year. As of July 1967, the entire family was involved in out-patient psychiatric treatment at St. Francis Hospital.

One social phenomenon which was encountered repeatedly during crisis consultations was the situation which the MHS staff referred to as the "squeeze-out." In such cases a family was consciously or unconsciously forcing a child out of the home. Frequently, the child's school behavior became increasingly worse as he tried to get himself put out of the school and, consequently, removed from an untenable home situation. In the past year, several children have put this stragegy into words, as well as practice. The philosophy of the MHS on this issue has been described as follows:

> The dilemma of the child who needs to be thrown out of school brings up two more very lively issues, one the philosophy of diagnosis, the other the chaos of inter-agency communication about troubled children and their families.
>
> As to the first, diagnostic philosophy, one finds that the traditional categories and certainly the refined studies of intra-psychic dynamics, have little relevance when dealing with the 95% of disturbed children who will never receive 'therapy' in the traditional sense, i. e., therapy designed to deal with complexities uncovered by 'clinical' diagnosis diminishing in direct proportion as the pathology of the family and of the school increase.

> The only practical system becomes an ecological system of diagnosis, in which the intra-psychic factors are noted, but are only a part of the complex total diagnosis. The latter resembles a cauliflower more than the neat cucumber slice of clinical diagnosis, because it must include a description of the two ecological niches, the home and the school, in which the child must establish himself and grow. If he is in danger of being excluded from either of these, the child's condition is serious, regardless of his clinical diagnosis. Contrariwise, a child with a psychosis, or brain damage, or some other serious clinical diagnosis may, in our scheme, have a benign condition, if home and school are receiving and containing him, and fostering his growth.[15]

There are several alternatives for action in crisis consultations or regular school consultations:

1. If the child is considered a candidate for the adjustment class or resource room programs, an assignment can be made, either as a placement or on a temporary basis to secure additional functional, diagnostic information about the child. If his school does not contain this special class program, the child may be transferred to a school which does.
2. A recommendation may be made to maintain the child in the regular class program, making available occasional informal use of the adjustment class or resource room. This alternative includes the use of an elected faculty member to work with the child.

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[15] Stickney, p. 18.

3. Changes in the child's placement in his school, transfer to another teacher or to another existing program, or transfer to another school may be recommended.
4. A referral to a community agency such as a hospital, a family case work agency, or a psychiatric clinic may be indicated.
5. The child may be placed on a part-time schedule in order to verify the "squeeze-out" situation, test the workability of the family, or share with the family the responsibility for teaching the child appropriate school behavior.
6. With severely disturbed children, a medical excusal may be given with appropriate recommendations for placement.
7. Some combination of these alternatives may be implemented.

In-Service Education. It was recognized early in the development of the MHS Program that any successful mental health effort in a school system must begin by providing real service to the schools' most urgent problems. Other mental health programs foundered because they were relatively selective, choosing the more "workable" of the difficult children referred to them by the school.

Following the MHS philosophy, all referrals were accepted, including such cases as a family having a 32-year-old record with community social agencies. Early referrals tended to be children who were aggressive, hostile, destructive, and unmanageable and whose problems were the most visible. After some success was demonstrated with

these children, less obviously disturbed children, the withdrawn and the fearful, were identified and referred.

It was also recognized by the MHS staff that merely expanding the number of crisis consultations scheduled and extending the number of special class programs would not be effective comprehensive mental health measures. Such efforts, while essential, would for the most part be a matter of "catching casualties." In order to create an effective school mental health program with preventive aspects to meet the growing need of containing and educating emotionally disturbed children, it became increasingly imperative to plan and implement a broad program of in-service education for school personnel.

Such a plan was implemented through the participation of school personnel in the consultation conferences described earlier. In addition, regularly scheduled weekly seminars were conducted during the school year. The participating groups are described in Table I.

The seminars for the preprimary and kindergarten teachers met after school. This arrangement proved unsatisfactory since the discussion of complex interpersonal relationships is difficult, if not impossible, at the end of a strenuous working day. The three other seminars (elementary instructional supervisors, vice-principals, and the faculty of Wightman Elementary School) met during the school day. At Wightman, teachers were relieved by interested parents for one hour per week so that they could attend the seminars.

TABLE 1

Description of Mental Health Seminar Groups

Type of Personnel	Number of Participants	Weeks of Duration
Preprimary Teachers	12	24
	25	12
Kindergarten Teachers	29	15
Elementary Instructional Supervisors	18	9
Vice-principals	10	27
Wightman (Total Faculty)	21	27
Total	115	114

The meetings were conducted informally by a MHS psychiatrist and social worker, who avoided imposing an agenda on the groups. The participants were encouraged to provide the content for each meeting, so that their own primary needs would be met. The teachers' seminars were centered, for the most part, on discussions of problem situations which had been encountered. Although the supervisors and the vice-principals occasionally brought up case material for discussion, they were more concerned with broad educational and sociological issues which were imbedded in the school system.

Informal feedback from the participants indicated that they had found the seminars to have real and practical value. It is hoped that released time can be secured so that further in-service education programs can be implemented. The planning of such programs is at the preliminary stage.

Inter-agency Conferences and Other Activities. In addition to the inclusion of appropriate agency representatives in school consultation conferences, the MHS staff participated in, or initiated, many meetings during the year which were designed to improve communication with other agencies. The purpose of some of the meetings was the implementation of joint planning efforts for meeting mental health needs in the community. Several meetings, for example, were scheduled with personnel from Western Psychiatric Institute and Clinic and St. Francis Hospital, both of which are involved in developing community mental health centers. There were frequent contacts with the mental health staff of the Allegheny County Public Schools, the Health and Welfare Association, the Child Welfare Services, The Mental Health Bureau of the Allegheny County Department of Health, and the Pennsylvania Mental Health Association.

The MHS staff also consulted with out-of-town groups who were in the process of establishing mental health programs in their schools. These consultations usually involved a full day or more of observing various components of the MHS Program and discussion with MHS staff.

The Director of the MHS Program is currently a consultant to Carnegie Institute of Technology's program to revise their teacher training curriculum and has made six video-tapes as part of the project. He is also serving as consultant to Project Upward Bound, a program

designed to motivate and support talented underachievers. He has appeared several times on WQED, Pittsburgh's educational television station, and has participated on panels or presented papers before such groups as the National Convention of the Council for Exceptional Children, the American Psychiatric Association, the Menninger Clinic, the International Convocation on Children and Adults with Learning Disabilities, the National Association of Mental Health, the New York State Mental Health Association, the South Carolina Mental Health Association, and other state mental health groups around the country.

The Coordinator of the MHS Program was a panel member at the annual Pennsylvania Mental Health Conference. He also presented a report to the Comprehensive Vocational Rehabilitation Planning Project for Pennsylvania. Both he and the MHS Director will be panel members at the International Conference of the Association for Pupil Personnel Workers in the fall of 1967. With the Director and Research Consultant, the Coordinator of the MHS Program has also been invited to present a workshop on mental health at the fall convocation of the Pennsylvania Federation of the Council for Exceptional Children.

Other activities of the MHS staff included the publication of an article describing their program in the Journal of the International Association for Pupil Personnel Workers. Staff members have also delivered between 40 and 50 speeches to local community organizations such as PTA's, settlement houses, and social agencies.

Population Served by the MHS Program. Eli M. Bower's operational definition of the emotionally disturbed child includes the following points:

1. An inability to learn, which cannot be explained by intellectual, sensory, or health factors
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers
3. Inappropriate types of behavior or feelings under normal conditions
4. A general pervasive mood of unhappiness or depression
5. A tendency to develop physical symptoms, pains, or fears associated with personal or school problems.[16]

Barbara Bateman's even broader view of "problem" children includes those with reading or communication problems and sensory-motor deficiencies. She classifies these children as having "learning disabilities" which frequently result in disturbed school behavior.[17]

Estimates of the incidence of emotional disturbance among children, according to Bower's definition, average about 10 percent.[18] In 1965,

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[16] "The Emotionally Handicapped Child and the School; An Analysis of Programs and Trends," Exceptional Children, XXVI (1959), 182-188.

[17] "Learning Disabilities," Exceptional Children, XXXI (1964), 166-167.

[18] The Early Identification of Emotionally Handicapped Children in School, (Springfield, Illinois, 1960), p. 11.

it was estimated that Allegheny County had at least 39,000 emotionally disturbed children.[19]

Criteria for Eligibility. Standards set by the Department of Public Instruction and adopted by the State Council of Education on September 20, 1961 have served as generai guidelines for admission to the MHS Program:

1. Children whose social and/or emotional problems are so severe that, in their regular classrooms, they are prevented from functioning normally or from making educational progress at a rate and to an extent commensurate with their abilities
2. Children whose serious emotional problems necessitate their working with specially qualified teachers who can give them individual attention and assistance
   a. Children whose behavior may be a destructive influence on other children
   b. Children whose environment is disorganized or inadequate
   c. Children who are severely disturbed and unresponsive to the usual educational opportunities
   d. Children whose behavior is organically determined but who have the potential to participate in group learning experiences

[19] Report of the Committee on Services for Emotionally Disturbed Children, p. B-5.

with specially qualified teachers in a protective school environment

Description of Population Served. From September 1966 to June 1967, 727 children from 6 to 19 years of age were referred to the program. Of these, 75 were admitted to the adjustment class program in the elementary schools, and 225 were admitted to the resource room program in the secondary schools. Thus, a total of 300 children participated in the MHS special class program. For the remaining 427 referrals, the MHS staff recommended adjustments which the school could make, provided support to the children in regular class placements, or referred them to community agencies. A limited number (12) of these children were excluded from school because of the severity of their disturbances.

Tables 2 and 3 present a breakdown of participants in the special class programs by sex and age.

TABLE 2*

Composition of MHS Special Class Programs by Sex

Level	Boys	Girls
Elementary Schools	82%	18%
Secondary Schools	63%	37%

*The data reported in Tables 2, 3, and 4 are as of Feb. 28, 1967.

TABLE 3

Composition of MHS Special Class Programs by Age*

Age	Percent	Age	Percent
19	1	14	1
18	2	13	1
17	7	12	8
16	13	11	15
15	24	10	19
14	28	9	31
13	23	8	8
12	2	7	8
		6	5

* Secondary school age range--12 to 18 years
Elementary school age range--6 to 14 years

As is indicated in Table 2, the percentage of boys in the program drops from 82 percent in the elementary school to 63 percent in the secondary school. In Table 3, it should be noted that although the age range in the secondary school program is from 12 to 19 years, 75 percent of the children are from 13 to 15 years old. Although the age range in the elementary school program is from 6 to 14 years, 65 percent of the children are from 9 to 11years old.

In analyzing the reasons for referral, five categories of behavior emerged in the secondary schools and four in the elementary schools. The percentage of participants referred for each of these reasons is presented in Table 4.

TABLE 4

Composition of MHS Special Class Programs
by Reasons for Referral

Secondary Schools	Percent	Elementary Schools	Percent
Aggressive	52	Aggressive	42
Withdrawn	38	Withdrawn	24
Pre-delinquent	3	PMD and MBD	31
Immature	2	Miscellaneous	3
Pre-schizophrenic, miscellaneous	5		

Aggressive behavior includes hostility, disruption, rebellion toward authority, lack of self-control, and hyperactivity. Withdrawn behavior includes fearfulness, depression, confusion, and under-achievement. It is interesting to note that, among the reasons for referral, perceptual-motor dysfunction (PMD) and suspected minimal brain damage (MBD) were reported for 31 percent of the elementary school population, but not at all in the secondary schools. In both elementary and secondary schools the greatest percentages of children were aggressive.

Because the original funding for the classes came from OEO, the six elementary classes and the six secondary classes were located in high-risk, low-income school districts. Thus, the children in the MHS special class program were relatively homogeneous in socioeconomic level. One additional adjustment class, located in a middle-class school district, was in existence before the inception of the MHS Program. Since it is under the direction of the Section on Special Education, it

will not be described in this report.

Description of Staff. The present staff consists of the following members:

1. A Psychiatrist-Director who provides leadership for the program, conducts in-service programs for school personnel, participates in the evaluation of candidates for the program, provides crisis consultations and psychiatric first aid in emergencies, plans and develops program activities, and performs administrative duties
2. A half-time Psychiatric Consultant who performs similar activities in consultation, evaluation, psychiatric first aid, and in-service education
3. A Coordinator who schedules the varied activities of the program, supervises the social workers, handles emergencies, communicates with community agencies, and performs administrative duties
4. Three social workers who assist in evaluating children for placement in the MHS Program, define and record issues, perform case work functions directly or through the school social worker, assist the psychiatrist in evaluating children in the crisis consultations, and conduct related activities
5. Twelve teachers for the adjustment class and resource room programs and eight classroom aides who provide a suitable

climate and educational help for the children in the program. The teachers communicate with regular teachers in the schools and meet regularly with the MHS staff, activities which are especially important because of the acute scarcity of trained mental health professionals

Statement of the Problem

Program Description

In order to determine whether or not the MHS Program is operating as it was originally conceived, it was necessary to gather additional descriptive information. Although the primary focus of the study was on the special class component of the program, this should not imply that the other components are less important. The special classes are simply the most visible segment of the program and, therefore, the most accessible to detailed examination.

Specifically, the following questions were raised:

1. How were the adjustment class and resource room programs used?
2. What were the principal activities in these classes?
3. Which lines of communication were developed and used?
4. What problems were most frequently presented?
5. What was the educational history of the children in the special class program?

Program Effects

An exploratory effort was made to assess and evaluate the effects of

the MHS Program--both on student participants and on school personnel.

To this end answers were sought for the following specific questions:

1. Were there changes in the achievement, performance, school citizenship, and attendance and tardiness of the children in the adjustment classes and resource rooms?

2. Were there changes in the attitudes and information about mental health among the school personnel who had had some degree of contact with the MHS Program?

3. How was the program perceived and evaluated by the principals of the schools in which the adjustment classes and resource rooms were located?

Method

Program Description

In September 1966, efforts were begun to design data collection forms to be used by the adjustment class and resource room teachers and by the MHS social workers. These instruments are included in Appendix A.

The MHS-2 form was developed to determine the problem most frequently presented, the subjects most frequently tutored, and the proportion of time spent in various activities in the resource room. It was completed by all resource room teachers every week for each child in the program. This was particularly important for obtaining information about the resource room which, because of its emphasis on one-to-one tutoring and remedial work and its flexibility of use, was not amenable to observation. A similar form, the MHS-2a, was designed to collect

descriptive information about the adjustment class program. It was filled out monthly by the adjustment class teachers for each child in the program. A random sample of the MHS-2 and the MHS-2a was drawn and analyzed.

Other data collection forms included the MHS-3, completed by the adjustment class and resource room teachers to provide a record of the frequency of their contacts with other personnel, and the MHS-5, submitted by the MHS social workers for the same purpose. The Student Data Cards (see Appendix B) were used to collect information about failure and citizenship marks in grades 1, 2, and 3 for the students who participated in the adjustment class and resource room programs. This information was gathered from school records in June and July of 1967.

Program Effects

The following information for the 1965-1966 and the 1966-1967 school years was compiled for each of the 300 students who had been in the adjustment class and resource room programs: (1) achievement test scores in reading and arithmetic, (2) report card grades in reading and arithmetic, (3) citizenship grades, and (4) absence and tardiness records. Data were collected in July 1967 from school records, using the Student Data Cards (see Appendix B).

A teacher rating scale (see Appendix C) was constructed and administered to all teachers (regular, adjustment class, and resource room)

who had taught any one of the students enrolled in the special class program during the 1966-1967 school year. Teachers were instructed to evaluate changes in the performance and behavior of these students by ranking them on a four point scale: marked improvement, some improvement, no improvement, or deterioration. A total of 1392 ratings were secured and analyzed.

A questionnaire was developed to measure attitudes toward mental health in a school context, mental health concepts, and information about the MHS Program. This information was pre-tested on two sections of graduate students at the University of Pittsburgh. It was administered in October 1966 to 654 school personnel in the 12 schools where there were adjustment classes and resource rooms and the regularly scheduled consultation conferences. Post-test scores were obtained by administering the questionnaire again in May 1967. It was also administered to the faculties of two secondary and three elementary schools in similar socioeconomic areas which had not received extensive services from the MHS Program.

In order to determine how the program was perceived and evaluated by the principals of the twelve schools which had adjustment classes and resource rooms, an interview schedule was devised (see Appendix D). Interviews were conducted by the Research Consultant during February and March of 1967.

Results

Program Description

As is indicated in Table 5, the problem most frequently presented by resource room students in all but one school was "personal crisis." In that school "relations with teachers" was the most frequently presented. No single problem emerged as predominant, demonstrating some heterogeneity in this aspect of the student population.

TABLE 5

Percentage of Problems Presented by Resource Room Students

Problem	Schools					
	1	2	3	4	5	6
Personal crisis	17	30	29	18	22	36
Relations with peers	14	11	13	16	19	13
Feelings about self	14	6	13	18	13	1
Relations with teachers	13	9	3	8	34	9
School crisis	11	6	3	13	4	9
Depression	11	10	13	8	3	10
Other school problems	8	22	18	7	5	21
Relations with family	12	6	8	12	-	1

Table 6 shows that mathematics was the most frequently tutored subject in all but one school, a school where the resource room teacher professed some discomfort with that subject. Of the other activities in the resource room, discussion and conversation on a one-to-one basis occupied the highest percentage of time as is shown in Table 7.

TABLE 6

Frequency of Subjects Tutored in the Resource Room Program

Subject	Schools					
	1	2	3	4	5	6
Mathematics	27	33	1	14	88	19
English	1	28	12	-	45	6
Social studies	-	-	3	6	-	10
Other subjects	18	5	3	2	40	5

TABLE 7

Percentage of Time Spent on Activities in the Resource Room Program

Activity	Schools					
	1	2	3	4	5	6
Discussion-conversation	32	48	41	40	30	40
Supervised study	30	28	23	18	20	17
Limited conversation	22	12	15	18	30	20
Inquiry about program	16	12	21	24	20	23

Although most of the students used the program on a regularly scheduled basis, considerable informal activity took place--unscheduled visits to the resource room, contacts with the resource room teacher in the halls, and drop-in visits before and after school. The variations revealed in Table 8 may be attributed to differences in school organization and climate, location and accessibility of the resource room, and teacher style.

TABLE 8

Percentage of Students' Use of the Resource Room Program

Use	Schools					
	1	2	3	4	5	6
Scheduled visit	32	57	26	46	86	70
Unscheduled visit	28	19	35	37	14	22
Contact in hall	20	12	1	19	-	4
Visit before/after school	20	12	38	8	-	4

For the adjustment class program, information on the percentage of time spent on various activities is given in Table 9.

TABLE 9

Percentage of Time Spent on Activities in the Adjustment Class Program

Activity	Schools					
	1	2	3	4	5	6
Reading	17	20	18	25	17	-
Arithmetic	13	20	11	20	14	-
Language arts	13	17	8	24	13	-
Social studies	7	4	1	2	1	-
Science	12	2	5	6	1	-
Other subjects	13	--	12	1	11	-
Perceptual-motor training	--	10	8	3	21	-
Group activity	--	12	15	9	14	-
Creative activity	--	12	14	9	8	-
Other activity	25	3	8	1	--	-

Although one adjustment class teacher submitted no data, the other classes furnished a somewhat consistent pattern of activity. Instruction in reading exceeded instruction in arithmetic, unlike the resource room program in which mathematics was the most frequently tutored subject. The variability of the percentage of time spent in perceptual-motor training could be explained by the fact that the teacher in School 5 had been trained in a university which emphasized that orientation, and the teacher in School 2 had taken summer courses there. No striking differences in the program were revealed, despite differences in the training and experience of the teachers, teacher style, and population. The teacher in School 1 was inexperienced and untrained and left the program at the end of the school year. The teacher in School 2 left the program at the end of the school year in order to study for an advanced degree.

Information on the adjustment class and resource room teachers' contacts with other personnel is given in Table 10.

TABLE 10

Frequency of Adjustment Class and Resource Room Teachers' Contacts with School Personnel

Category of School Personnel	Adjustment Class Teachers						Resource Room Teachers					
	1	2	3	4	5	6	1	2	3	4	5	6
Coordinator	-	-	-	-	-	-	101	186	118	76	228	11
Principal	49	131	49	35	17	-	77	180	9	19	168	10
Vice-principal	-	-	-	-	8	-	84	251	57	36	-	5
Counselor	-	47	-	-	-	-	68	94	16	36	-	-
School social worker	14	21	6	30	17	-	121	76	75	20	83	2
Psychologist	4	6	4	2	17	-	5	49	11	4	13	-
MHS staff	8	28	12	16	17	-	8	36	42	22	140	2
Technoma	-	-	-	-	-	-	12	55	202	15	45	8
Regular teacher	-	30	39	35	-	-	117	375	454	76	1381	9
Agency	-	-	3	2	-	-	-	12	8	1	4	-
Doctor or nurse	-	14	7	3	-	-	83	6	22	9	104	-
Observation	-	3	7	-	-	-	11	22	-	-	1	-
Parent	-	22	29	30	1	-	-	28	1	7	-	-
Other	-	11	24	32	-	-	-	7	70	6	1	-

One adjustment class teacher failed to submit any data, and two submitted only partial data. Despite differences between teachers in systematically recording these contacts, a revealing profile of activity and communication emerged.

In the adjustment class program, the findings confirm the important role played by the principal. Adjustment class teachers also had a considerable amount of contact with regular teachers, the MHS staff, school social workers, and parents.

The pattern of communication in the resource room is similar in general contours to that of the adjustment class with some expected differences. Reflecting a more complex program which involves a larger number of students and school personnel, the frequency of contact is much greater than in the elementary school program. Differences in

administrative style and assignments are evident in a greater frequency of contact with the Coordinator-Counselor and less frequency of contact with the principal and the vice-principal. The most frequent contacts were made with regular classroom teachers. As in the adjustment class program, the resource room teachers had a considerable amount of contact with the MHS staff and the school social workers. Technoma personnel served in a consultative relationship with the resource room teachers. There were two secondary schools in which a school physician and a school nurse were actively involved in consultation with the resource room program.

Table 11 presents more information about these contacts by showing their distribution across the ten months of the 1966-1967 school year.

TABLE 11

Monthly Frequency of Adjustment Class and Resource Room Teachers' Contacts with School Personnel

Category of School Personnel	Sept	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
Coordinator	42	33	103	113	153	103	63	87	65	6
Principal	28	32	81	80	139	80	71	102	53	18
Vice-principal	-	15	31	75	118	66	59	55	27	-
Counselor	3	6	28	49	66	36	27	28	19	3
School social worker	9	23	44	53	112	63	39	56	63	3
Psychologist	4	7	16	21	16	13	10	22	5	1
MHS Staff	6	27	28	34	49	43	35	49	42	18
Technoma	5	57	23	47	51	49	28	40	35	2
Regular teacher	14	198	241	296	411	335	298	342	319	136
Agency	-	-	3	-	5	6	12	2	2	-
Doctor or nurse	2	21	25	16	43	37	11	27	60	9
Observation	-	1	10	4	7	3	4	1	14	-
Parent	2	2	14	16	26	12	16	20	7	4
Other	-	12	11	22	24	15	26	26	14	3

As is shown in Table 11, activity rose sharply in November and reached a peak in December and January. A second rise in activity, though less pronounced, occurred in April. This finding tends to confirm the hypothesis of the MHS staff that mental health crises increase in frequency before and after the Christmas holidays and again in the early spring.

Table 12 presents the MHS social workers' average number of monthly contacts with other personnel.

TABLE 12

Average Monthly Frequency of MHS Social Workers' Contacts with Other Personnel

Category of Personnel	Frequency
MHS staff	24.0
School social worker	20.0
Meetings	18.5
Other agencies	16.4
Principals	16.0
Coordinator	13.0
Special class teacher	10.7
Counselor	9.3
Parent	9.0
Psychologist	8.6
Vice-principal	7.8
Children	6.5
Regular teacher	5.8
Other	4.4
Medical personnel	2.8
Technoma	2.8

Aside from communication with the MHS staff, the high frequency of contact with the school social workers tends to confirm the consultative relationship which is assumed in the MHS Program. The data generally

seem to substantiate the expected direction of the activities of the MHS social workers.

Table 13 presents the percentage of students in the special class programs who had repeated the first, second, or third grade.

TABLE 13

Percentage of Students in the Resource Rooms and Adjustment Classes Who Had Repeated Grades 1, 2, or 3

Resource Room* School	Percentage of Students	Adjustment Class* School	Percentage of Students
1	36	1	22
2	64	2	--
3	64	3	--
4	89	4	43
5	50	5	30
6	42	6	50
Mean percent	57	Mean percent	39
*N = 225		*N = 75	

Percentages for the adjustment classes appear to be lower than those for the resource rooms, but the adjustment class data were incomplete and also reflected a smaller population than did the resource room data. Apparently a considerable proportion of the children in the special class program had been demonstrating serious learning problems as early as the primary grades. This was further substantiated by an examination of their citizenship grades in the first three grades of school. Information on this subject is presented in Table 14.

TABLE 14

Average Number of Citizenship Checks for Students in the MHS Special Class Program

Resource Room* School	Number	Adjustment Class* School	Number
1	9.4	1	12.5
2	3.8	2	---
3	10.0	3	9.7
4	4.7	4	12.6
5	11.3	5	20.0
6	5.0	6	8.4

*N = 225 *N = 75

A check mark in citizenship on the report card indicates a need for improvement. Therefore, the higher the number of check marks, the poorer is the student's conduct and behavior. In determining citizenship the teacher rates the student on whether he is courteous, is kind, shows self-control, gets along with others, respects regulations, pays attention, follows directions, works neatly, uses time and materials wisely, accepts responsibility, keeps neat and clean, has good sleep and other habits, and follows safety rules. All the children in the adjustment classes or resource rooms had poor citizenship marks in grades 1, 2, or 3. The average number of check marks received was 9.7.

Program Effects

The analysis of student data on achievement, report card grades, citizenship, and absence and tardiness and the analysis of the pre- and

post-test scores of the questionnaire administered to school personnel did not show statistically significant differences.

The results of the teachers' ratings of students are recorded in Table 15.

TABLE 15

Percentage of Children in the Adjustment Class and Resource Room Programs Exhibiting Change as Rated by Teachers

Item	(1) Marked Improvement	(2) Some Improvement	(3) (1) and (2) combined	(4) No improvement	(5) Deterioration
Relationship with other children	15	54	69	24	7
Relationship with authority	19	50	69	22	9
Participation in class activities	15	49	64	26	10
General work and study habits	13	46	59	31	11
Following directions	14	49	63	29	9
Paying attention	14	48	62	27	10
Pride in accomplishment	17	45	62	29	9
Conformity to school rules	14	50	64	26	11

Because each student was rated by all of his teachers, regular and special, full-time students in the adjustment classes and resource rooms may have had only one rating, while part-time students may have been rated by several teachers. The total number of ratings obtained was

1392. Marked improvement was indicated in 13 to 19 percent of the ratings, occurring primarily in the areas of "relationship with authority" and "pride in accomplishment." Between 7 and 11 percent of the ratings indicated "deterioration" of behavior.

In examining column 3, a combination of columns 1 and 2 which indicates some degree of positive change in behavior, "relationship with other children" and "relationship with authority" showed the highest percentage of improvement (69 percent). "Conformity to school rules" and "participation in class activities" showed the next highest percentage of improvement (64 percent).

Responses of the principals to the oral interviews are summarized in the following pages.

Question 1: What do you expect the MHS Program to accomplish?

The principals felt that the program would identify and evaluate emotionally disturbed children, help them to make adjustments to school, and help them learn how to learn. The program would provide new alternatives for handling these children which would permit regular teachers to attend to the needs of their other children and relieve the school of the inappropriate custody of severely disturbed children. Thus, the school would be able to continue its normal functions, and disturbed children would be assisted in returning to regular classes. Other expected benefits were improved teacher morale, an improved climate

in the school, an increase in the school's holding power, and a reduced suspension rate.

Question 2: In general, how do you think the MHS Program is functioning?

Principals stated that the program was going well, with procedures operating smoothly and the program serving its intended purpose. They remarked that the program had demonstrated some success in educating disturbed children and returning them to regular classes and that teacher morale had improved.

Question 3: In what ways have you been able to use the program as a resource?

The principals stated that the program was useful as a preventive measure for seventh- and eighth-grade students in a junior-senior high school. It provided a resource for serving temporarily disturbed children, and it offered a safe place for ventilation. It had been valuable in the assessment and evaluation of children referred for service, permitting closer observation of behavior. The flexibility of the program permitted short-term, unofficial, temporary placements which were of value to the whole school.

Question 4: What do you think is the strongest component of the program? The weakest?

The strongest components of the MHS Program were the special class teachers and the psychiatric consultation and on-going support provided to the school. Principals emphasized that the program provided a place

that was not stigmatized and a person (the special teacher) who had the time and the skills to work in depth with emotionally disturbed children. There was an opportunity for individual attention, with limits and structure. The program was not punitive. The approach of the MHS staff was considered to be very practical, and showed an understanding of the problems faced by the schools. Principals felt that the consultation conferences were profitably utilized as training sessions for school personnel who attended and participated. The flexibility of the program was recognized as a strength, as was the fact that emotionally disturbed children were maintained, as much as possible, in the mainstream of activity in the school.

The weakest aspect, it was felt, was the program's inadequate size. Further, it was believed that the Counselor-Coordinator in the secondary schools had insufficient time to perform his duties associated with the program, in addition to his regular work as Counselor. Inadequate or improper space for the adjustment class or resource room was another problem mentioned. The absence or scarcity of treatment facilities for children in the community left severely disturbed children in the school by default. One principal expressed the view that it was impossible, or at least undesirable, to "mix mental health and education" and that an out-patient psychiatric facility would be more efficacious than the MHS Program.

Question 5: Do you think there is sufficient communication between the adjustment class or resource room teacher and the regular teachers? Do regular teachers attend the consultation conferences?

Nine of the 12 principals believe that communication had been excellent and that regular teachers had been attending the conferences. Of the remaining three, one principal attributed poor communication to the fact that the resource room was located in another building, another took the position that "the less a regular teacher knew about a child's social history, etc., the better," and the third said that poor communication was the product of an inexperienced teacher.

Question 6: What, if anything, would you like to change in the program?

The high school principals requested additional counselor time to relieve the counselor who had the responsibility of acting as coordinator of the MHS Program in their schools. It was felt that substitute teachers would be helpful in relieving regular teachers for attendance at consultation conferences. There were strong recommendations for the expansion and extension of the program. One principal requested the installation of a one-way mirror so that the special class could be observed.

Another principal made the following recommendations:

1. A new program for children with perceptual-motor dysfunctions--educational, remedial, and possibly experimental

2. The development of, and experimentation with, new educational materials for the instruction of emotionally disturbed children

3. A training program for adjustment class aides and an extension of training for the adjustment class teachers

Question 7: Have you observed any changes in the behavior of the children who are in the adjustment class or resource room?

Most secondary principals felt that it was too early in the development of the program to see much change. Elementary principals reported considerable improvement in the children's school behavior and a decrease in referrals to the principal's office for disciplinary action.

Question 8: How is the referral and screening procedure functioning?

All of the principals reported that the referral and screening procedures were working smoothly and satisfactorily. No changes were recommended.

Question 9: Do you think that the program can effectively serve a cluster of schools?

Two of the elementary school principals reported that almost all of the children referred to the program came from outside their schools. It was noted that these schools had been served by a mental health team for about a year before the establishment of the adjustment class and the faculties had participated in a program of in-service education. Apparently they were able to handle their own disturbed children, possibly as a result of that training. The other principals expressed willingness to have the adjustment class and resource room program serve a group of schools, but they felt this was essentially unrealistic.

They believed that each school needed, and should have, its own adjustment class or resource room.

Discussion and Conclusions

The descriptive data which were collected yielded a picture of the program as it actually operated. The resource room data revealed a high degree of flexibility in the use of the program. The unscheduled visits, the contacts in the halls, and the visits before and after school hours confirmed the assumption that the program would serve the "self-referrals" as well as those officially assigned to the program.

Although "personal crisis" and "relations with teachers" were the most frequently presented problems, the resource room program was able to deal with students whose problems were distributed across six other categories, again demonstrating the flexibility and versatility of the program.

Descriptive data from the adjustment classes revealed a consistent pattern of activity resembling that of an academically structured self-contained elementary school program. The addition, late in the 1966-1967 school year, of a special education instructional supervisor should contribute to the continued stabilization and between-class consistency of the program during the 1967-1968 school year.

Thirty-one percent (or almost a third) of the children in the adjustment classes were referred because of suspected perceptual-motor

dysfunction or minimal brain damage. Specific remedial training was provided by those teachers who had been trained in perceptual-motor development. In order to further investigate this aspect of the findings, it was decided that, beginning in October 1967, a part-time perceptual-motor development consultant would work with the MHS Program. At the outset, he will have three major purposes:

1. To diagnose, screen, and evaluate all the children in the adjustment class program

2. To arrive at a more definitive estimate of the incidence of perceptual-motor deficits in the adjustment class population

3. To train adjustment class teachers in remedial techniques which will become a part of the classroom program

Patterns of communication which emerged from the data confirmed the central role of the principal in the elementary schools and of the Counselor-Coordinator in the secondary schools. The high frequency of contact between the special class teachers and the regular teachers substantiated the degree of intra-faculty communication necessary to the functioning of the program. The activities of the MHS social workers, represented in part by their contacts with other personnel, demonstrated a high degree of communication and consultation as had been expected. Much of their activity occurred through meetings and conferences with school social workers, other agencies, the principal, the Counselor-Coordinator, and the special class teacher.

Although there were no statistically significant differences in the

student data collected and analyzed, several factors must be considered in interpreting these findings. It was discovered that approximately 57 percent of the students in the resource room program and 39 percent of those in the adjustment class program had failed and repeated first, second, or third grade. The children in the adjustment classes and the resource rooms had received an average number of 9.7 citizenship marks in grades 1, 2, or 3. These findings indicate that a sizable proportion of these children had demonstrated school problems which were identified as long as seven, eight, or nine years ago.

Children with a history of school failure and "problem" behavior will not only be academically retarded, but also are likely to possess strong negative feelings about school and school activities. Their academic achievement and performance are not amenable to rapid or dramatic change. For some children, improved ability merely to maintain themselves in a classroom situation may be viewed as marked improvement. Visible behavior changes may be assigned diverse values. Aggressive behavior, for example, may be regarded in a mental health context as a sign of positive growth in a child who has been fearful and withdrawn and yet perceived by a regular teacher as wholly undesirable.

There are also intervening variables which are beyond the control or influence of the MHS Program: family situation, treatment by other social agencies, school climate, teacher personality, community factors, and deprivations (material and/or emotional). The children included in

this study frequently were delegates from disturbed or disorganized families. For some children, the intervention of the MHS Program may be a critical turning point toward adjustment from what has been a disastrous school career. For others, who may already be severely damaged it may only represent a pause or a slowing-down of a deterioration which may well be irreversible.

Another consideration is the fact that the length of the children's participation in the program varied from ten months to as little as two months, on either a full-time or a part-time basis. It is unrealistic to expect that the single intervention of a mental health program would, in a relatively short period of time, be able to neutralize, counteract, or reverse the influence of all the variables mentioned. A longitudinal study covering a larger sample of time would be required to determine the effects of the special class program.

It may well be that measurements of isolated aspects of the total child, such as reading achievement or attendance, do not adequately represent important changes which may take place. A longitudinal study may need to take a more global approach or employ more sophisticated and refined measures.

The absence of statistically significant differences in the questionnaires used to assess attitudes of school personnel toward mental health may be the result of an instrument that is not sufficiently discriminant or

sensitive to change. It also may be premature to expect major attitudinal changes after a relatively short period of time and limited engagement with school personnel.

In view of the complexities involved in educating emotionally disturbed and socially maladjusted children--educational, sociological, physiological, developmental, and psychological--it is encouraging to examine the results of the teachers' rating scale. Of the 1392 ratings secured from special and regular teachers, 69 percent showed improvement in "relationship with other children" and "relationship with authority." Sixty-four percent showed improvement in "participation in class activities" and "conformity to school rules."

These positive findings were corroborated by the responses of the principals whose schools had the adjustment class and resource room programs. They reported a decrease in the number of referrals to the office for disciplinary action and an increase in teacher morale. Their major criticism of the program was its inadequate size. Almost all of them perceived the special class component of the MHS Program and the supporting consultation conferences as highly desirable and effective in meeting the urgent mental health needs in their schools.

The findings presented in this report demonstrate the kinds of success the MHS Program has achieved. The MHS staff has provided services to large numbers of disturbed children without developing long waiting lists. The children in the special classes have begun, according

to their teachers, to demonstrate some improvement in their school behavior. In-service education of school personnel has begun and will continue. Principals have welcomed this addition to the existing array of ancillary services to their schools. The role of the school in dealing with emotionally disturbed and socially maladjusted children has been clarified, and the existence of serious gaps in mental health services in the community has been identified or confirmed. Through the vision and energy of the Maurice Falk Medical Fund and the Pittsburgh Board of Public Education, a promising beginning has been made toward meeting the mental health needs of students. At least another year, or more, of operation and evaluation will be required to provide more definitive evidence of the effects of the MHS Program.

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APPENDICES

APPENDIX A

MHS 2
9/66

OFFICE OF SCHOOL SERVICES
DIVISION OF MENTAL HEALTH SERVICES

Pittsburgh Public Schools

Pupil's Name_____ WEEKLY SERVICE REPORT--RESOURCE ROOM School_____
Week of_____ Teacher_____

						Impressions of Student Behavior
Tutoring in_____						
School problem:						
Test						
Teacher relationship						
Homework						
Learning difficulty						
Other						
Casual inquiry						
General conversation						
Limited conversation, guarded						
Personal problems:						
Relation with peers						
Relation with family						
Feelings about self						
Fears						
Depression						
Other						
Supervised study						
Crisis						
School						
Home						
Personal						
Other						
Scheduled visit						
Unscheduled visit						
Contact in hall						
Visit before/after school						
Time: (minutes)						

60 / 5-61

MHS 2A
9/66

Pittsburgh
Public
Schools

OFFICE OF SCHOOL SERVICES
DIVISION OF MENTAL HEALTH SERVICES

MONTHLY SERVICE REPORT--ADJUSTMENT CLASS

Pupil's Name _____ School _____

Month of _____ Teacher _____

Dates:																						
Tutoring in:																						
Reading																						
Arithmetic																						
Language																						
Social Studies																						
Science																						
Other _____																						
Other _____																						
Perceptual-motor work																						
Other activities:																						
Group																						
Creative _____																						
Other _____																						
Number of period in adjustment class																						

Impressions of behavior:

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OFFICE OF SCHOOL SERVICES
DIVISION OF MENTAL HEALTH SERVICES

Pittsburgh
Public
Schools

MONTHLY REPORT OF CONTACTS

Month_____

School_____

Teacher_____

Contact with:

Dates																					
Coordinator																					
Principal																					
Vice - principal																					
Counselor																					
Home and School Visitor																					
Psychologist																					
MHS staff																					
Technoma																					
Teacher																					
Other agency																					
Doctor or nurse																					
Observation																					
Parent or guardian																					
Other:_____																					
Other:_____																					

MHS-5
9/66

Pittsburgh
Public
Schools

OFFICE OF SCHOOL SERVICES
DIVISION OF MENTAL HEALTH SERVICES

MONTHLY REPORT OF CONTACTS

Month_____ Social Worker_____

Contact with:	Total
Parents	
Children	
Coordinator	
Principal	
Vice-principal	
Counselor	
Home and School Visitor	
Psychologist	
MHS staff	
Technoma	
Teacher (Reg.)	
Teacher (MHS)	
Other agency	
Medical personnel	
Meeting	
Other	

Monthly summary of cases:

Total cases active at end of previous month		
New cases added		
Cases reopened (same school year)		
Cases closed		
Total cases active at end of this month		
Miscellaneous case contacts (casual)		

Number of children in resource room and adjustment class at end of this month:

School	Number

APPENDIX B

STUDENT DATA CARD

Name_____ No. _____

Grade_____ Birth Date_____ School_____

	Rdg. Ach.	Rdg. R. C.	Arith. Ach.	Arith. R. C.	Cit. or No Cks.	Abs.	Tardy
1965-66:							
1966-67:							

Repeated: 1st gr.___ 2nd gr.____ 3rd gr.____

No. of cit. cks.: 1st gr._____ 2nd gr.____ 3rd gr._____

66/ 5-67

APPENDIX C

Pittsburgh
Public
Schools

TEACHERS' RATING FORM FOR STUDENTS IN THE SPECIAL CLASS PROGRAM*

THIS FORM WAS DESIGNED TO HELP DETERMINE THE DEGREE OF PROGRESS MADE BY THE STUDENTS WHO HAVE BEEN ASSIGNED TO THE ADJUSTMENT CLASS OR RESOURCE ROOM PROGRAM. A SEPARATE ANSWER SHEET IS ATTACHED FOR EACH OF THESE STUDENTS. THE STUDENT'S NAME APPEARS ON THE SHEET PERTAINING TO HIM. PLEASE COMPARE THE CHILD'S PRESENT PERFORMANCE AND BEHAVIOR WITH HIS PERFORMANCE AND BEHAVIOR AT THE BEGINNING OF THIS SCHOOL YEAR AND INDICATE YOUR RATING ON EACH OF THE 11 ITEMS. YOUR OBSERVATIONS AND PROFESSIONAL JUDGMENTS WILL BE HELPFUL IN FUTURE PLANNING FOR THIS CHILD.

1. Relationship with other children:
   (1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

2. Relationship with authority:
   (1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

3. Participation in class activities:
   (1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

4. Work and study habits generally:
   (1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

5. Following directions:
   (1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

6. Paying attention:
   (1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

* Teachers actually recorded their ratings on digitek answer sheets. This page reproduces the directions and items of the answer sheets.

7. Completing assignments:
(1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

8. Pride in accomplishment:
(1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

9. Conformity to school rules and regulations:
(1) Marked improvement (2) Some improvement (3) No improvement (4) Deterioration

10. Did you know this child before he/she entered the adjustment class or resource room?
(1) Yes (2) No

11. How many months has this child been in your class this year (1966-1967)?
(1) 7 to 10 (2) 4 to 6 (3) 0 to 3

APPENDIX D

Interview Schedules for Principals

1. What do you expect the MHS Program to accomplish?

2. In general, how do you think the MHS Program is functioning?

3. In what ways have you been able to use the program as a resource?

4. What do you think is the strongest component of the program? The weakest?

5. Do you think there is sufficient communication between the adjustment class or resource room teacher and the regular teachers? Do regular teachers attend the consultation conferences?

6. What, if anything, would you like to change in the program?

7. Have you observed any changes in the behavior of the children who are in the adjustment class or resource room?

8. How is the referral and screening procedure functioning?

9. Do you think that the program can effectively serve a cluster of schools?